

care interdisciplinary team to address the special care needs of the inmate.

A. Care Team Members and Responsibilities:

The following disciplines are considered to be the core team members. Others may be added on an as needed basis.

1. The attending physician will be responsible for discussing with the inmate:
 - a. course of treatment and when in their clinical judgment, no further active treatment is indicated;
 - b. any palliative treatment options available;
 - c. discuss need for advanced directives and determine the patient's decision regarding code status.
2. The primary nurse will be responsible for:
 - a. convening and conducting the clinical care treatment team;
 - b. coordinating clinical care services;
 - c. providing for nursing care and implementation of the medical regimen;
 - d. facilitating security clearance for visits.
3. A mental health clinician will be responsible for assessing mental health status, counseling, and support. A social services member of mental health will review advanced directives.
4. The chaplain will be responsible for:
 - a. providing spiritual support;
 - b. assisting with funeral arrangements;
 - c. communicating with family/designated persons;
 - d. coordinating family visits with security and nursing;
 - e. coordinating volunteer visits with the Chaplain and security.
5. Security will be responsible for approving and/or arranging for authorization for family/volunteer visits within the prison or acute care hospital.
6. A pharmacist will be responsible for providing assistance to the inmate in care medication therapy management and in procuring and dispensing ordered medications.
7. A dietician will be consulted to assess the nutritional status and providing for the inmate's dietary needs.
8. A medical records staff member will be responsible for assisting in the development and completion of advanced directives and in ensuring that the inmate's health record is complete in accordance with medical record keeping standards.
9. Case counselor/designee will be responsible for being the liaison with the inmate's housing unit and offender system.

B. Apparent Death:

Upon the apparent expected death of a critically/terminally ill inmate within the prison, the following steps will be taken:

1. Nursing will be responsible for notifying:
 - a. Platoon Commander
 - b. On-call DOC Physician and/or chief medical officer
 - c. Administrative Director
 - d. Director of Nursing
2. The on-call physician will be responsible for pronouncing death and notifying the State Medical Examiner.
3. Nursing will be responsible for preparing the body for removal by the funeral director.
4. Health Services Center security will be responsible for safeguarding the inmate's personal effects.
5. The chaplain will be responsible for notifying family/designated members of the death.
6. The platoon commander will be responsible for:
 - a. arranging for on-site access by the funeral director;
 - b. notifying:
 - 1) Warden

- 2) Investigations
- 3) Public Information Officer
- 4) Commissioner
- 5) Chaplain

REFERENCES:

Standards for the Administration of Correctional Agencies
Second Edition. Standards

Standards for Adult Correctional Institutions
Fourth Edition. Standards
4-4425

Standards for Adult Community Residential Services
Fourth Edition. Standards

Standards for Adult Probation and Parole Field Services
Third Edition. Standards

Other

MACLEOD/pf

Attachments

Declaration made this _____ day of _____, I _____
(month/year) (name)

If at any time I should have an incurable injury, disease, or illness certified to be a terminal condition or a permanently unconscious condition by 2 physicians who have personally examined me, one of whom shall be my attending physician, and the physicians have determined that my death will occur whether or not life-sustaining procedures are utilized or that I will remain in a permanently unconscious condition and where the application for life-sustaining procedures would serve only to artificially prolong the dying process, I direct that such procedures be withheld or withdrawn, and that I be permitted to die naturally, with only the administration of medication, sustenance, or the performance of any medical procedure deemed necessary to provide me with comfort care.

YES NO (Circle your choice and initial beneath it.
If you do not choose “yes”, artificial nutrition and
hydration will be provided and will not be removed.)

(initials)

I understand the full import of this declaration, and I am emotionally and mentally competent to make this declaration.

Signed _____
(your name)

State of _____ County

1. The declarant signed the instrument as a free and voluntary act for the purposes expressed or expressly directed another to sign for him.
2. Each witness signed at the request of the declarant, in his presence, and in the presence of the other witness.
3. To the best of my knowledge, at the time of the signing the declarant was at least 18 years of age, and was of sane mind and under no constraint or undue influence.

_____ Witness

_____ Witness

To be completed by notary.

Sworn to and signed before me by _____, declarant
_____ and _____, witnesses on _____
(date)

Signature _____

Official Capacity _____

New Hampshire RSA 137-H
Attachment 2

DISCLOSURE STATEMENT FOR THE DURABLE POWER OF ATTORNEY FOR HEALTH CARE
THIS IS AN IMPORTANT LEGAL DOCUMENT. BEFORE SIGNING THIS DOCUMENT YOU SHOULD KNOW
THESE IMPORTANT FACTS:

Except to the extent you state otherwise, this document gives the person you name as your agent the authority to make any and all health care decisions for you when you are no longer capable of making them yourself. "Health care" means any treatment, service or procedure to maintain, diagnose or treat your physical or mental condition. Your agent, therefore, can have the power to make a broad range of health care decisions for you. Your agent may consent, refuse to consent, or withdraw consent to medical treatment and may make decisions about withdrawing or withholding life-sustaining treatment. Your agent cannot consent or direct any of the following:

- Commitment to a state institution
- Sterilization
- Or termination of treatment if you are pregnant and if the withdrawal of that treatment is deemed likely to terminate the pregnancy unless the failure to withhold the treatment will be physically harmful to you or prolong severe pain which cannot be alleviated by medication.

You may state in this document any treatment you do not desire, except as stated above, or treatment you want to be sure you receive. Your agent's authority will begin when your doctor certifies that you lack the capacity to make health care decisions. If for moral or religious reasons you do not wish to be treated by a doctor or examined by a doctor for the certification that you lack capacity, you must say so in the document and name a person to be able to certify your lack of capacity. That person may not be your agent or alternate agent or any person ineligible to be your agent. You may attach additional pages if you need more space to complete your statement.

If you want to give your agent authority to withhold or withdraw the artificial providing of nutrition and fluids, your document must say so. Otherwise, your agent will not be able to direct that. Under no conditions will your agent be able to direct the withholding of food and drink for you to eat and drink normally.

Your agent will be obligated to follow your instructions when making decisions on your behalf. Unless you state otherwise, your agent will have the same authority to make decisions about your health care, as you would have had if made consistent with state law.

It is important that you discuss this document with your physician or other health care providers before you sign it to make sure that you understand the nature and range of decisions which may be made on your behalf. If you do not have a physician, you should talk to someone else who is knowledgeable about these issues and can answer your questions. You do not need a lawyer's assistance to complete this document, but if there is anything in this document that you do not understand, you should ask a lawyer to explain it to you.

The person you appoint as agent should be someone you know and trust and must be at least 18 years old. If you appoint your health or residential care provider (e.g. your physician or an employee of a home health agency, hospital, nursing home or residential care home other than a relative), that person will have to choose between acting as your agent or as your health or residential care provider; the law does not permit a person to do both at the same time.

You should inform the person you appoint that you want him or her to be your health care agent. You should discuss this document with your agent and your physician and give each a signed copy. You should indicate on the document itself the people and institutions who will have signed copies. Your agent will not be liable for health care decisions made in good faith on your behalf.

Even after you have signed this document, you have the right to make health care decisions for yourself as long as you are able to do so, and treatment cannot be given to you or stopped over your objection. You have the right to revoke the authority granted to your agent by informing him or her or your health care provider orally or in writing.

This document may not be changed or modified. If you want to make changes in the document you must make an entirely new one.

You should consider designating an alternate agent in the event that your agent is unwilling, unable, unavailable or ineligible to act as your agent. Any alternate agent you designate will have the same authority to make health care decisions for you.

This power of attorney will not be valid unless it is signed in the presence of two (2) or more qualified witnesses who must both be present when you sign and acknowledge your signature. The following persons may not act as witnesses:

- The person you have designated as your agent
- Your spouse
- Your lawful heirs or beneficiaries named in your will or a deed

Only one of the two witnesses may be your health or residential care provider or one of their employees.

DURABLE POWER OF ATTORNEY FOR HEALTH CARE

I, _____, hereby appoint _____ of

(name)

(name of agent)

(agent's address and phone #)

as my agent to make any and all health care decisions for me, except to the extent I state otherwise in this document or as prohibited by law. This durable power of attorney for health care shall take effect in the event I become unable to make my own health care decisions.

Statement of Desires, Special Provisions and Limitations Regarding Health Care Decisions.

For your convenience in expressing your wishes, some general statements concerning the withholding or removal of life-sustaining treatment are set forth below. (Life-sustaining treatment is defined as procedures without which a person would die, such as but not limited to the following: cardiopulmonary resuscitation, mechanical respiration, kidney dialysis or the use of other external mechanical and technological devices, drugs to maintain blood pressure, blood transfusions and antibiotics). There is also a section that allows you to set forth specific directions for these or other matters. If you wish you may indicate your agreement or disagreement with any of the following statements and give your agent power to act in those specific circumstances:

1. If I become permanently incompetent to make health care decisions and if I am also suffering from a terminal illness, I authorize my agent to direct that life-sustaining treatment be discontinued.

_____ YES NO (Circle your choice and initial beside it).

(initials)

2. Whether terminally ill or not, if I become permanently unconscious I authorize my agent to direct that life-sustaining treatment be discontinued.

_____ YES NO (Circle your choice and initial beside it).

(initials)

3. I realize that situations could arise in which the only way to allow me to die would be to discontinue artificial feeding (artificial nutrition and hydration). In carrying out any instructions I have given in # 3 or # 2 above or any instructions I may write in # 4 below, I authorize my agent to direct that (circle your choice of (a) or (b) and initial beside it).

_____ (a) artificial nutrition and hydration *not* be started or, if started, be discontinued or

(initials)

_____ (b) although all other forms of life-sustaining treatment be withdrawn, artificial nutrition and hydration *continue* to be given to me.

(initials)

If you fail to complete item 3, your agent will not have the power to direct the withdrawal of artificial nutrition and hydration.

4. Here you may include any specific desires or limitations you deem appropriate, such as when or what life-sustaining treatment you would want used or withheld, or instructions about refusing any specific types of treatment that in inconsistent with your religious beliefs or unacceptable to you for any other reason. You may leave this question blank if you desire. (attach additional pages as necessary)

In the event that the person I appoint above is unable, unwilling, unavailable or ineligible to act as my health care agent, I hereby appoint _____ of _____ as alternate agent.

(name of alternate agent)

(address and phone # of alternate agent)

I hereby acknowledge that I have been provided with a disclosure statement explaining the effect of this document. I have read and understand the information contained in the disclosure statement.

The original of this document will be kept at

(address)

and the following persons and institutions will have signed copies:

In witness whereof, I have hereunto signed my name this _____ day of _____

(day)

(Month/year)

(your signature)

I declare that the principal appears to be of sound mind and free from duress at the time the durable power of attorney for health care is signed and that the principal has affirmed that he or she is aware of the nature of the document and is signing it freely and voluntarily.

Witness _____ Address _____

Witness _____ Address _____

To be completed by notary

STATE OF NEW HAMPSHIRE, COUNTY OF

The foregoing instrument was acknowledged before me this _____ day of _____, by
(day) (month/year)

- Notary Public/Justice of the Peace

My Commission Expires

New Hampshire RSA 137-J